

Case Number:	CM14-0089826		
Date Assigned:	09/10/2014	Date of Injury:	01/11/2006
Decision Date:	10/10/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/13/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Surgery and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

55 year old female claimant with an industrial injury dated 01/11/06. Exam note 04/10/14 states the patient returns with "low back pain, shoulder pain and left wrist pain." The patient also reports that the pain is causing her to have trouble sleeping at night. Physical exam demonstrates that the patient has tenderness to palpation over the AC joint line, in addition to suprascapular muscles over the supraspinatus tendon. The drop arm test, impingement sign, Hawkin's/Neer's test, thumbs down test, and cross arm adduction test were all positive. The patient had a range of motion of 130' flexion and abduction, and 40' external and internal rotation. The patient had a rotator muscle strength test of a 4/5. There was swelling, tenderness, a decreased range of motion, and an effusion with a mild deformity and atrophy over the ulnar styloid. The shoulder MRI provides evidence for impingement and the wrist MRI demonstrates a TFCC tear. Treatment includes a left wrist arthroscopic and debridement.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Left Wrist Arthroscopic and Debridement: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Diagnostic Arthroscopy - Forearm, Wrist and Hand Chapter Offices Visits - Forearm, Wrist and Hand Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270.

Decision rationale: CA MTUS/ACOEM Chapter 11, Forearm, Wrist and Hand Complaints, page 270 recommends referral for hand surgery for patients with red flags, failure to respond to conservative management and have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention. In this case the exam note from 4/10/14 does not demonstrate evidence of failure of conservative management with bracing, activity modification or injection. Therefore the request for Left Wrist Arthroscopic and Debridement is not medically necessary.

Pre-Op Medical Clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.